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Legal implications of the Wendland case for end-of-life decision making

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In *Conservatorship of Wendland,* the California Supreme Court established a high standard of proof for end-of-life decision making on behalf of patients who are incompetent but conscious and have a court-appointed conservator.[1] The court's opinion establishes an easier standard of proof for some situations where there is no conservator, but the opinion leaves many questions unanswered. We address the implications of *Wendland* for health care professionals in California and, in particular, the questions of what evidence of a patient's end-of-life wishes is required for physicians to withhold life-sustaining treatment and how strong that evidence must be in various situations.

PREVIOUS RIGHT-TO-DIE CASES IN CALIFORNIA

California law establishing the right to refuse medical treatment began at the far end of cognitive impairment—coma—after the 1976 case of *Matter of Quinlan,* in which a New Jersey court held that physicians could withdraw a respirator from a permanently unconscious patient at the family's request.[2]

The first post-Quinlan California case, in 1983, was *Barber v Superior Court,* in which physicians had discontinued a surgery patient's artificial nutrition and hydration (ANH) at the family's request after the patient had suffered cardiac arrest and become comatose.[3] The court held that the physicians could not be charged with murder.

The next group of California cases was at the opposite end of the spectrum, involving patients who were seriously ill but fully cognitive. In *Bartling v Superior Court*, a competent patient suffering from emphysema, an abdominal aneurysm, and lung cancer wanted his physicians to remove his ventilator.[4] The court held that he could require them to do so over their objections. In *Bouvia v Superior Court*, the court held that a quadriplegic woman with cerebral palsy who was restricted to bed in a public hospital could require her physicians to withdraw ANH.[5]

Then came two cases in 1988 involving patients who were neither comatose nor fully cognitive but in a persistent vegetative state (PVS). In *Conservatorship of Drabick,* the court said that a court-appointed conservator could require physicians to withdraw ANH from a car-accident victim who had been in a PVS for 5 years.[6] In *Conservatorship of Morrison,* the elderly PVS patient was in a public hospital where physicians had refused her conservator's request to withdraw ANH but offered to transfer the patient to another facility where others would do so.[7] The

court held that the physicians could refuse on moral grounds to withdraw ANH but could be required to transfer the patient, as they had offered.

These cases seemed to have established a broad right for a patient or a substitute decision maker to direct the withdrawal of ANH.

Conservatorship of Wendland was unprecedented because it occupied a middle ground: between competency and PVS.

CALIFORNIA'S STATUTORY HEALTH CARE DECISIONS LAW

In addition to judicial decisions on the right to die, California has extensive legislation on the subject: the Health Care Decisions Law.[8] This law authorizes a conservator or a surrogate whom the patient has designated orally or in a written directive to direct that life-sustaining treatment, including ANH, be withheld or withdrawn in accordance with the patient's "wishes to the extent known." If such wishes are not known, the conservator or surrogate must decide in accordance with the patient's "best interest."[9]

THE DECISION IN *CONSERVATORSHIP OF WENDLAND*

The legal issue in *Wendland* concerned the level of proof necessary to establish a patient's "wishes to the extent known."

The normal standard of proof in civil cases is "preponderance of evidence," which means more likely than not (ie, >50%). The highest standard of proof, used in criminal cases, is proof "beyond a reasonable doubt." Between these two standards is an intermediate standard of proof, "clear and convincing evidence," which has been used in civil cases involving fundamental or important rights. The phrase "clear and convincing" means explicit and unequivocal.

The California Supreme Court held that the law requires clear and convincing evidence of the patient's wishes under circumstances like *Wendland,* where a conservator requests withdrawal of ANH from an incompetent but conscious patient.

The court required clear and convincing evidence in that situation because of a difference between patient-designated surrogates and court-appointed conservators. People designate surrogates in whom they repose "the highest degree of confidence," whereas a court-appointed conservator who might be unrelated to the conservatee "cannot be presumed to have special knowledge of the conservatee's health care wishes."[10] Thus, the court concluded, the higher standard of proof is required to withhold medical treatment from a conscious conservatee to "help to ensure the reliability of the decision" by the conservator.[11] The court ignored the fact that Robert Wendland's conservator was his wife and thus arguably could be presumed to have special knowledge of Robert's wishes (perhaps because the court did not want trial courts to be required to decide conflicting claims among relatives who assert some special connection to, and knowledge about, a conservatee).

The court was careful, however, to limit its decision: The clear and convincing evidence standard is justified "only when a conservator seeks to withdraw life-sustaining treatment from a conscious, incompetent patient who has not left legally cognizable instructions for health care or appointed an agent or surrogate for health care decisions."[12] In contrast, the lower "preponderance of evidence" standard will apply to patients who either are permanently unconscious, executed an advance directive, designated a surrogate, or have a conservator and are conscious but the decision is not intended to result in death.[13]

WENDLAND'S IMPLICATIONS FOR CALIFORNIA MEDICAL PRACTICE

The *Wendland* opinion clearly prescribes the standard of proof for the situations the court mentioned. But the opinion raises some perplexing questions.

What evidence will satisfy the clear and convincing standard for conscious conservatees?

The *Wendland* opinion does not say what constitutes clear and convincing evidence, other than to hold that Robert's preincompetency comments—that he "would not want to be a vegetable" or to be "kept alive with tubes"—were not clear and convincing in light of his condition. Such use of everyday language is typical. Few people discuss their end-of-life wishes in the jargon of lawyers or physicians or in great detail. Thus, in the course of medical practice, a physician will rarely encounter a situation where a conservatee's preincompetency comments are specific enough to permit withholding life-sustaining treatment. Conservatorship will, therefore, almost always mean that life-sustaining treatment cannot be withheld.

What evidence will satisfy the "preponderance of evidence" standard in situations where it applies?

Again, the *Wendland* opinion does not say what constitutes preponderant evidence, but here it gives a clue. The court thought it had to require clear and convincing evidence to protect Robert's life. The implication, then, is that the preponderance of evidence standard, which his preincompetency comments met, would not have protected his life. This indicates that comments like Robert's, that he "would not want to be a vegetable" or to be "kept alive with tubes," can be sufficiently preponderant to allow withdrawal of life-sustaining treatment pursuant to an advance directive or at the direction of a surrogate or conservator in situations where the preponderance standard applies.

What is the standard of proof when no advance directive, surrogate, or conservator exists?

Patients commonly have not executed an advance directive and have no surrogate or conservator, and on this point *Wendland* is subject to conflicting interpretations. On the one hand, reading the opinion as narrowly as the court prescribed, the standard seems to be preponderance of evidence because clear and convincing evidence is required only when the patient has a conservator. On the other hand, the justification for requiring clear and convincing evidence in *Wendland*—that the higher standard of proof is required to ensure the reliability of a decision by someone not designated by the patient—would seem to apply with equal force when there is no advance directive, surrogate, or conservator.

On this point, the authors of this article disagree. One of us (J B E) believes that the *Wendland* court plainly intended its opinion to apply narrowly so that, where there is no advance directive, surrogate, or conservator, physicians may withdraw life-sustaining treatment at the direction of family and/or friends who supply preponderant evidence of end-of-life wishes like Robert Wendland's. The other (J C K) believes that the *Wendland* opinion's reasoning inevitably leads to the conclusion that clear and convincing evidence is required in these situations.

Should conservatorships be avoided because they invoke the higher standard of proof?

A startling result of the *Wendland* opinion that the court might not have intended is that it apparently creates an incentive to avoid conservatorships for seriously ill persons unless they have explicitly and unequivocally stated their end-of-life wishes in an advance written directive. A conservatorship will invoke the clear and convincing evidence standard, greatly restricting end-of-life decision making. In such situations, physicians should counsel the patient's family and friends to consider the benefits of conservatorship versus the burden imposed by the higher standard of proof in deciding whether to seek a conservatorship.

What if an advance directive designates an agent but includes no specific or pertinent instructions?

Wendland implies that when there is an advance written directive, the standard of proof is preponderance of evidence. Such requirement of proof suggests that it is not enough simply for the directive to designate an agent; there must also be some evidence of end-of-life wishes, whether stated in the directive or shown by preincompetency comments. Thus, if the directive includes no specific instructions, or its instructions do not seem to cover the situation at hand, family and friends should be consulted to determine whether the patient said anything before incompetency that would satisfy the preponderance standard. If there is no such evidence of preincompetency wishes, the law is unclear, but it is arguable that the designated agent must decide based on the Health Care Decisions Law's "best interest" standard rather than the "wishes to the extent known" standard.

What is required for conscious developmentally disabled conservatees who were never competent?

Developmentally disabled adults commonly have court-appointed conservators. Under *Wendland,* the conservatorship invokes the clear and convincing evidence standard for end-of-life decision making if the patient is conscious. But if the patient was never competent, there cannot be clear and convincing evidence of the patient's "wishes to the extent known." In these cases, the Health Care Decisions Law will allow withdrawal of life-sustaining treatment only if it is in the patient's "best interest," which the *Wendland* opinion says also must be proved for conscious conservatees by clear and convincing evidence—a daunting task.

Have *your* patients written an advance health directive?

CONCLUSION: THE NEED FOR ADVANCE WRITTEN DIRECTIVES

The most important message from *Wendland* is that people who want a say in their end-of-life decision making should execute an advance written directive, which will avoid the burden of the higher standard of proof. Currently, some 10% to 20% of Americans execute advance written directives.[14] *Wendland* challenges health care pro-

fessionals to increase that number. Whenever possible, physicians should discuss end-of-life wishes with their patients, urge them to execute advance written directives, and include records of pertinent conversations and copies of directives in patients' medical files.

Authors Jon B Eisenberg, a partner with the law firm of Horvitz and Levy LLP specializing in civil appeals, filed a pro bono "friend of the court" brief in the California Supreme Court for 6 health care organizations and 43 bioethicists in support of Rose and Robert Wendland. J Clark Kelso, a Professor of Law and Director of the Capital Center for Government Law and Policy at the University of the Pacific's McGeorge School of Law, is a legal commentator on public policy issues in California.

References

1 *Conservatorship of Wendland,* 26 Cal 4th 519 (2001).
2 *Matter of Quinlan,* 70 NJ 10 (1976).
3 *Barber v Superior Court,* 147 Cal App 3d 1006 (1983).
4 *Bartling v Superior Court*, 163 Cal App 3d 186 (1984).
5 *Bouvia v Superior Court*, 179 Cal App 3d 1127 (1984).
6 *Conservatorship of Drabick,* 200 Cal App 3d 185 (1988).
7 *Conservatorship of Morrison,* 206 Cal App 3d 304 (1988).
8 California Probate Code §4600 et seq.
9 California Probate Code §§2355, 4684 & 4714.
10 *Conservatorship of Wendland,* 26 Cal 4th 545 (2001).
11 *Conservatorship of Wendland,* 26 Cal 4th 546 (2001).
12 *Conservatorship of Wendland,* 26 Cal 4th 551 (2001).
13 *Conservatorship of Wendland,* 26 Cal 4th 555 (2001).
14 29 Cal Law Rev Commission Report at 16 (1999).